Proposed Changes for the Dane County SSI MC Medicaid Contract 2005-2007

Log #	Location in 02-03 Contract	Change Submitted By	Summary of Change	Health Plan Comments in Dark Red	In Draft Contract	DHFS Comments in Blue
1a	**Article I – Definitions Section III. E. 5.**	**WCA NAMI DCMHR MHA Independence First**	**Care coordination:** For persons with mental illness care coordination should be provided by and supervised by persons with mental health expertise. **Care plan development and definition of care plan:** These definitions and the material in Section III. E. 5. should be revised to include the following: *Care plan should be developed within 30 days of the assessment *Consumer must be able to review initial care plan before deciding whether to opt out of the MCO *For persons with serious mental illness and/or substance abuse care plan should include mental health and/or substance abuse treatment, psychosocial rehabilitation services, and a crisis plan, based on the consumer's choice *Consumer and others involved in delivering services and providing informal supports should be involved in developing care plan	Recommend taking this statement out of the Care Coordination definition and revising it for inclusion under the Case Management definition to read: "For persons with serious mental illness, case management should be provided by and supervised by persons with mental health expertise". Add a definition of Serious Mental Illness according to BRC 1&2. This language should be removed. This is already addressed in the description of the care plan. Strike this provision since care plan is required to be member centered.	p. 2 p. 97 p. 26	Language added under Article I. Defiitions, page 2. **Language recommended by Health Plan added.** **Definition of Serious Mental Illness based on BRC 1&2 will be added** See Article VII. B. 1.a., page 97. See Article III. E. 5, page 26. **This language was removed, per Health Plan.** **This provision was left in, as the language is more specific than "member centered".**

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Log #	Location in 02-03 Contract	Change Submitted By	Summary of Change	Health Plan Comments in Dark Red	In Draft Contract	DHFS Comments in Blue
1b	**Article I – Definitions Section III. E. 5. (Cont.)**	**WCA NAMI DCMHR MHA Independence First**	*Care plan should clearly identify who will provide which services *Care plan should identify which services the MCO will provide and which services will be provided by others and how these services will be coordinated *If MCO is not providing services identified in the care plan, there should be referrals to appropriate providers (examples may be housing and vocational services) and a plan for following up on these referrals *Care plan should address integration of mental health and physical health care services *Care plan must be based on consumer choices regarding services and providers Consumer or guardian must sign the care plan and be given a copy *Copies of the care plan must be provided to all providers who are involved in providing services to the consumer pursuant to the care plan *MCO must ensure that services it is responsible for providing or funding under the care plan are provided to the consumer	This should be removed per HIPAA. Disagree with statement on providing care plans to **all** providers but rather leave that to the case manager discretion so sensitive MH/SA information is not shared indiscriminately. Examples are not covered services.. Under CSP, these services are coordinated and the referral management and coordination occurs with sub-contracted provider. No need to duplicate. Recommend replacing this statement with: The need for both services will be assessed and appropriately addressed in the care plan. Recommend replacing this statement with: All care plans will consider consumer choice and need. Agree with DHFS to not have a requirement for enrollee to sign care plan. Disagree with copies of care plan to all providers as stated above. This language is not necessary as it is already addressed in the contract.	p. 26 p. 24 p. 25 p. 24 p. 24 p. 27	Language added under Article III. E. 5., page 26. **Changed clause about providing care plans to all providers to: "If care plan is not provided to all providers, the case manager must document why."** **Language reflects that appropriate referrals should be made for non-covered services.** This should be consistent across the Milwaukee and Dane Programs, so there will not be a requirement to have the enrollee sign the care plan. **Language was added regarding care plans considering consumer choice and need.** **Added: "If care plan is not provided to all providers, the case manager must document why."** **Added language that requires documentation of why covered services were not provided.**

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Log #	Location in 02-03 Contract	Change Submitted By	Summary of Change	Health Plan Comments in Dark Red	In Draft Contract	DHFS Comments in Blue
1c	**Article I – Definitions Section III. E. 5. (Cont.)**	**WCA NAMI DCMHR MHA Independence First**	*Care plans for persons with serious mental illness should be reviewed at least every six months, not annually	Agree with DHFS revision.	p. 26	Language added under Article III. E. 5., page 26.
			*Any changes in the care plan must be approved by the consumer or guardian and documented	Agree with DHFS revision indicating any changes in the care plan must be "explained" to consumer or guardian and documented.		
			Comprehensive Assessment: For persons with mental illness and/or substance abuse the assessment must be conducted by individuals with expertise in these conditions. Assessment and care planning must be done in conjunction with each other.	Agree with DHFS revision indicating "serious mental illness".	p. 26	Language added under Article III. E. 5., page 26.
			Emergency Medical Condition: Psychiatric emergency should be defined to be an acute crisis situation for the consumer which may be due to a significant loss to the person (e.g., death of a loved one, loss of child custody, etc.), as well as risk of serious physical harm to self or others.	Remove per DHFS comments.		Emergency medical condition is defined in Federal Law in the Managed Care Rule 42 CFR 438.114
			Encounter: The list of services should be expanded to include non-office based mental health services such as psychosocial rehabilitation, community support programs, crisis services, case management, etc.	Remove. Do not add required services beyond those defined by Medicaid	p. 6	Language added under Article I. Definitions, Encounter, page 6. **The services cited are part of the Medicaid benefit package.**

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Log #	Location in 02-03 Contract	Change Submitted By	Summary of Change	Health Plan Comments in Dark Red	In Draft Contract	DHFS Comments in Blue
1d	**Article I – Definitions Section III. E. 5. (Cont.)**	**WCA NAMI DCMHR MHA Ind. First**	**Recovery:** The definition in HFS 36.03(23) [the CCS rules]	HFS 36.03 should be cited in the text.	p. 8 p. 8	Language consistent under Article I. Definitions, Recovery, page 8. **Added reference to HFS 36.03.**
2a	**Article III - Functions and Duties of the MCO** **B. General Provision of Contract Services**	**WCA NAMI DCMHR MHA Independence First**	**1.** There should be a specific list of Medicaid funded mental health services; these should include evidence based services, such as ACT teams and integrated mental health and substance abuse treatment, crisis intervention, psychosocial rehabilitation, psychotherapy, including trauma specific therapy, etc. The MCO should be encouraged to fund other services such as peer support and other consumer operated programs. This information should be included in the body of the contract and not just in Addendum II.	Agree with DHFS comment to refer to covered Medicaid services as defined in Wis Stat. As above, strike the provision on encouraging the MCO to provide peer support and other consumer operated programs to read: MCO when appropriate will refer to or coordinate with other needed services.	 p. 12 p. 20	The MCO is required to cover all Medicaid services. The complete list of covered procedure codes is too lengthy to include. All services listed in Section 49 of the State Statutes must be covered. See Article III. B. for reference to S. 49.46 (2) Wis Stats. **Language to the effect that: "The MCO is encouraged to make referrals when appropriate" was added and "encouraging the MCO to provide peer support and other consumer operated programs" was removed.** **The information in Addendum II was moved to the body of the contract.** .

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Log #	Location in 02-03 Contract	Change Submitted By	Summary of Change	Health Plan Comments in Dark Red	In Draft Contract	DHFS Comments in Blue
2b	**Article III - Functions and Duties of the MCO** **B. General Provision of Contract Services (Cont.)**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	**14. [and III. C.] - Medical Necessity and Court Ordered Services -** It should be clarified about who decides what services a person is to receive, who will provide them, and who will fund them when the recipient is under a Chapter 51 or 55 or other court order. Under Chapters 51 and 55 the county has responsibility to provide services for persons who are under court orders and to make decisions about what services the person will receive. If the person is enrolled in an MCO, there is potential for conflict between the county and the MCO; who has the final say must be clarified so the consumer is not stuck in the middle of the conflict. This also needs to be more clearly addressed in Addendum II.	Agree with DHFS contract language with 6/05 revisions. Language should be "in coordination" with the responsible legal authority for Chap 51/55 proceedings.	p. 140-141	See Addendum II, 3 and 5.on pages 140-141.

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Log #	Location in 02-03 Contract	Change Submitted By	Summary of Change	Health Plan Comments in Dark Red	In Draft Contract	DHFS Comments in Blue
3a	**Article III - Functions and Duties of the MCO** **E. MCO Care Management Services**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	For comments about case management and care plans see comments above under heading of care plan development and definition of care plan. In addition, the case management provided by the MCO should be coordinated with any other case management services being provided by another provider, such as a CSP or a CCS. There also needs to be a process for resolving disputes between the MCO case manager and a case manager from another program so the consumer is not caught in the middle.	Agree with DHFS contract language with 6/05 revisions. Remove language "such as CSP or a CCS" Sufficient to leave as is without the "such as."	p. 25	Language was added to Article III. 5. E. page 25 regarding care plan development and definition of care plan.

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Log #	Location in 02-03 Contract	Change Submitted By	Summary of Change	Health Plan Comments in Dark Red	In Draft Contract	DHFS Comments in Blue
3b	**Article III - Functions and Duties of the MCO** **E. MCO Care Management Services (Cont.)**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	**2. Assessment** This new section is a significant improvement since it incorporates requirements from HFS 36, the CCS rule. However, it does not go far enough. In particular it leaves out many of the domains identified in HFS 36.16. All of the following domains should be included in a comprehensive assessment for a person with serious mental illness: life satisfaction, basic needs, social network and family involvement, community living skills, housing issues, employment, education, finances and benefits, mental health, physical health, substance abuse, trauma and significant life stressors, medications, crisis prevention and management, and legal status (e.g. guardianship, court orders, etc.). It should also include information about current providers of services, medications, use of crisis services, including emergency rooms, any history of criminal justice involvement, and hospitalizations or other institutionalizations.	Contract should follow definition of "Assessment" used in SSI MC for Milwaukee County contract.	p. 25-26 p. 23	See Article III, Functions and Duties of the MCO, E. 2. g., page 25. The added language is being edited as of 8/05. **Language is consistent with Milwaukee contract with the addition of: g 2.) "trauma", and g 3.) "Use of crisis services including emergency rooms, any history of criminal justice involvement, and hospitalizations or other institutionalizations."**

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4	**Article III - Functions and Duties of the MCO** **F. Twenty-four Hour Coverage**	**WCA NAMI DCMHR MHA Independence First**	This section should require the provision of mental health crisis intervention services that meet the requirements of HFS 34, Subchapter III, which are the requirements for MA certification.	Agree with DHFS comment.	p. 10	See Article III. B. 1. d., the crisis intervention benefit is not covered by the MCO, it is carved out of the capitation rate.
5	**Article III - Functions and Duties of the MCO** **O. [Should be P.] Enrollee Handbook, Education and Outreach for Newly Enrolled Recipients**	**WCA NAMI DCMHR MHA Independence First**	The handbook and/or other materials should clearly explain the opt out process plus voluntary and involuntary disenrollment criteria and procedures. Other enrollee rights, including those under Sec. 51.61, Wis. Stats. and HFS 94, Wis. Admin. Code, should be spelled out. Education and outreach activities should include access to knowledgeable individuals to ask questions and should not rely on just written materials. There should be more proactive efforts to educate consumers about their rights and responsibilities and options.	Agree with DHFS comment.	p. 37	The enrollment booklet covers these procedures. See Article III. P. 7., page 37. Ombuds are available for enrollees for complex questions that may arise. The Department plans to contract with an external advocacy organization.

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6	**Article III - Functions and Duties of the MCO** **Q. Marketing and Informing Materials**	**WCA NAMI DCMHR MHA Independence First**	Again, potential enrollees should have access to knowledgeable, independent individuals to ask questions. Information about the SSI managed care initiative should also be sent to providers so they can help recipients understand what is happening and what their options are.	Agree with DHFS comment.		Ombuds are available for enrollees with complex questions that may arise. The Department plans to contract with an external advocacy organization.
7	**Article III - Functions and Duties of the MCO** **R. Choice of Health Professional**	**WCA NAMI DCMHR MHA Independence First**	In addition to choice of primary health care provider, there should be choice of mental health providers and care managers and the ability to change mental health providers and care managers.	Agree with DHFS comments.	p. 40	Enrollees have the option to opt out of the program if their mental health provider does not join the network. Also, network adequacy will be evaluated during the certification process. Particular attention will be given to the mental health provider network.

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Log #	Location in 02-03 Contract	Change Submitted By	Summary of Change	Health Plan Comments in Dark Red	In Draft Contract	DHFS Comments in Blue
8	**Article III - Functions and Duties of the MCO** **S. Quality Assessment/Performance Improvement** **2. d. QAPI Committee**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	**6.** At least three enrollees should be required members of the QAPI committee; they should be compensated by the MCO for their time serving on the committee.	Contract should follow the SSI Managed Care contract used for Milwaukee County MCOs where enrollees are able to contribute to the committee but not actually be voting members of the committee. It is the responsibility of the MCO to undertake quality improvement activities based on member input and other appropriate factors.	p. 42	See Article III, Section S. 2. d. 6), page 42. Language was added to the effect that: 1.) The MCO must demonstrate orientation of consumers to participate fully on the QAPI committee, and 2.) The Department will review the MCO's process to involve consumers in the QAPI process. **Above language was left in, per discussion of Dane SSI MC Advisory Committee.**
9	**Article III - Functions and Duties of the MCO** **3. Monitoring and Evaluation**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	While it is anticipated that there will be much more discussion of this topic in the next several months, especially for the Dane County project, there must be measures of consumer recovery, both as defined by the consumer and by use of standardized objective measures. Use of the ROSA tool is strongly encouraged. Also quality medication monitoring using a process similar to that being implemented in the fee for service program is encouraged.	Agree with DHFS comment.		The Quality Assurance Workgroup is working on quality indicators for the program.

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10	**Article III - Functions and Duties of the MCO** **4. Access**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	Access to medications must be addressed. Any formularies and/or prior authorization processes may not be more restrictive than those used in the Medicaid fee for service program. [This should also be included in Section III. QQ. Prescription Drugs.]	Agree with DHFS contract language with 6/05 revisions. MCO must be allowed to develop its own formulary as long as the MA formulary is covered.	p. 65 p. 12	See Article III. Section Z. 4., page 65. See Article III. Section B. page 12. Language was added to the effect that the MCO must be able to provide all Medicaid covered services.

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11	**Article III - Functions and Duties of the MCO** **AA. Coordination and Continuation of Care**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	**1. - 3.** We support the language which maintains existing providers during the assessment and initial care planning process. Language should be clarified so that once the care plan has been developed which identifies service providers, the consumer then must have at least 30 days to decide whether to opt out of the MCO. **8.** The decision to change a mental health or substance abuse treatment provider should be the enrollee's and not the MCO's. Continuity of care also needs to be addressed for enrollees who temporarily become ineligible for MA due to incarceration, institutionalization, or other reasons.	Use DHFS language. Agree with DHFS comment. Cannot guarantee the same provider or services if enrollee is ineligible for a period of time longer than 6 months. The enrollee will be reassessed at the time of re-enrollment to determine appropriate care plan at that time.	p. 65	Article III. Section Z. 1, page 65. The MCO is responsible for managing the care of the enrollee. Options for the enrollee feedback/choice include: omsbuds, external advocate, grievance, fair hearing and opting out. The system does re-enroll people with 6 months or less of a break in eligibility.

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12	**Article VII. Enrollment and Disenrollment** **B. Enrollment**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	We support the following process: Within 30 days of an individual being enrolled in the plan, the MCO must contact any existing Medicaid funded health care providers for the individual and invite them to join the network. The enrollee's assessment is completed within 60 days of enrollment (unless earlier assessment is warranted). The care plan is developed within 30 days of the completion of the assessment. The care plan clearly identifies the services and the service providers to be provided/funded by the MCO. The consumer is given at least 30 days from the development of the care plan to decide whether to opt out of the MCO. Contract language needs to more clearly describe this process.	Agree with DHFS contract language with 6/05 revisions.	p. 65	See Article III. Section Z. 1., page 65.
13a	**Article VII. Enrollment and Disenrollment** **C. Disenrollment**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	Any person disenrolling from the MCO must be given realistic information about the availability of services in the fee for service system and assistance in accessing these services if he/she does disenroll.	Agree with DHFS comment for addressing this issue.		The Enrollment Broker is trained to provide this information to people disenrolling from the program.

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13b	**Article VII. Enrollment and Disenrollment** **C. Disenrollment (Continued)**	**WCA** **NAMI** **DCMHR** **MHA** **Independence First**	**1. Voluntary** After the lock-in period enrollees should be allowed to disenroll for just cause: 1) if a service provider identified in the care plan drops out of the network and the consumer believes that the relationship with the provider is central to his/her recovery or to meet primary health care needs; 2) if access to services in the care plan is reduced by the MCO and the consumer believes that the reduction in services impairs his/her safety or interferes with meeting his/her recovery goals. **2. Involuntary** No disenrollment should be punitive to the consumer for his/her failure to follow treatment plans or other conditions. To provide greater protection to consumers we urge that there be internal and external advocate review of any involuntary disenrollment proposed by the MCO and mediation or another informal dispute resolution process attempted before a request for disrenrollment is sent to the Department.	Agree with DHFS. Current process is very comprehensive and allows consumer many choices for appeal. In some instances, the suggested language will violate privacy rules which cannot occur with appropriate ROI. Change language to: Internal and external advocates will be sent information on involuntary disenrollment at the same time the MCO sends a request to the Department.	p. 99	1.) The Department will grant exemptions for continuity of care reasons. Each case is decided on its own merits by a department clinician. 2.) See Article III. C. pages 99. Involuntary disenrollments are unusual and are only done after much effort has been made to work with the enrollee regarding any barriers to treatment. **Language changed to: Internal and external advocates will be sent info. on involuntary disenrollment at same time as Department.** Each request is reviewed by a department clinician and the enrollee has the right to a fair hearing if they are dissatisfied with a decision.

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14	**VIII. Grievance Procedures**	**WCA NAMI DCMHR MHA Independence First**	This section needs to clearly state that enrollees who are receiving services for mental illness, substance abuse, or developmental disabilities have the rights under Section 51.61, Wisconsin Statutes and HFS 94, Wisconsin Administrative Code. For violation of these rights the HFS 94 grievance procedure must be implemented and may be used in addition to the grievance procedure under the contract. There must be an independent external advocate available to enrollees to assist them with grievances, fair hearings, and other disputes or rights violations involving the MCO.	Strike revised language in Article VIII, second paragraph, p. 105. This is adequately addressed in grievance procedures.	p. 105	See Article VIII, second paragraph, page 105. **Language on rights under Section 51.61, Wisconsin Statutes and HFS 94, Wisconsin Administrative Code, per Health Plan.** An external advocate will be hired to serve the Dane Co. SSI MC Program.
15	**III. Functions and Duties of The MCO Section 8 Medical Records**	**Sarah Roberts, CLA**	On p. 47, e, second sentence: What does "actively monitor" mean? In other sections of the contract we can address various issues in our subcontracts with providers. We should be able to do this with Medical Records as well.		p. 47	It would be up to the MCO regarding how to "actively monitor". Examples of ways to actively monitor include chart reviews, audits, etc.

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16	**I. Definitions**	**Sarah Roberts, CLA**	CMS and the state for Family Care and Partnership have adopted "complaint" and "appeal" in place of grievance. That has helped distinguish between complaints about quality of service vs. denial or reduction of service leading to an appeal. It would be helpful to have consistent language	Agree with need to review grievance policy for consistency.	p. 7	The State is reviewing the grievance policy for all of its MCO contracts and will be addressing these issues within the next six months. (8/05)
17	**I. Definitions**	**Sarah Roberts, CLA**	"On p. 8, the language regarding care planning, etc. refers to 'member centric'" I find this very off-putting as it sound like something to do with geometry, not people. The old phrase, 'member centered' is good, clear phrase, used commonly and I would hope we could restore that phrase to this section."		p. 8	The term "member centric" has been changed to "member centered" wherever it occurs in the contract.

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18	**III. Functions and Duties of the MCO**	**Sara Roberts, CLA**	"In the QI section concerning the annual QI studies it states that the report of these studies is due Jan. 1 of the following year. First I would like to suggest that it be Jan. 31 of the following year. Sometimes projects are initiated in Jan and it shortens them to have to report by Jan 1 of the next year. What I really would like to advocate for though is that this contract adopt the strategy being used for Family Care and Partnership which is, using the BCAP Typology and reporting quarterly. QI projects have a life of their own and are not necessarily started and completed within one year. Quarterly reporting using BCAP accomplishes two things: it creates an ongoing record describing the project in various phases. It also respects that projects move along on their own time and end when they are complete."	BCAP should not be a mandated, but would be an acceptable format for PI projects.	p. 53	The report schedule in ADDENDUM III is being revised to include year 2007. We have considered the report schedule for other programs such as Milwaukee and would like to keep PIP reporting schedules uniform. **Changed language to reflect that the BCAP methodology is optional.**
19	**I. Definitions**	**Dr. Urban**	Insert language about face-to-face assessment, under "comprehensive assessment".		p. 3, 25	See Article I, Definitions, page 3. See Article III, E. 1. page 25.

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20	**II. Delegations of Authority**	**Dr. Urban**	Insert language under definition of "medical necessity": "The MCO must provide assessment and evaluation service ordered by a court. The actual provision of services is subject to the professional judgment of the MCO providers regarding the medical necessity of the service."	Agree with DHFS comment. No new language needed.	p. 20	Kept text as is to be consistent with HMO contract.
21	**II. Delegations of Authority**	**Dr. Urban**	Update language on family planning services.	Agree with DHFS revision.	p. 22	See Article III. B. 15., page 22.
22	**III. Functions and Duties of the MCO**	**Dr. Urban, Mary Laughlin**	Modified language regarding patient status and care plan reviews. Deleted language about enrollee reviewing initial care plan, as it is covered elsewhere in contract.	Agree with DHFS revision.	p. 26	See Article III. E. 4 and 5., page 26.
21	**III. Functions and Duties of the MCO**	**Dr. Urban**	Add #1-8 from-- Part 3: Scope of Contractor Activities, Special Managed Care Organizations Quality Improvement Review, Section 120.002, "Purpose of the Review Process" to Section S "Quality Assessment/Performance Improvement (QAPI)" #10 "External Quality Review Contractor", c.	Agree with DHFS revision. -."	p. 53-54	See Article III. S. 10. c., page 53-54.
22	**III. Functions and Duties of the MCO**	**Sherrel Walker, Dr. Urban**	Add "Ten steps for completing a performance improvement project" under Section S. "Quality Assessment/Performance Improvement (QAPI)"	CLA understands there would be a choice for QAPI between BCAP and other methods. Mandating BCAP for all PI projects would be too restrictive.	p. 57-60	See Article III. S. 13. B., page 57-60.

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23	**Article VII Enrollment and Disenrollment A. Covered Population**	**Mary Laughlin**	Add the mentally retarded population to those that are not eligible for the program. Delete language about multiple MCOs.	Agree with DHFS revision.	p. 97	See Article VII. A., page 97.
24	**Article VIII Grievance Procedures**	**Dr. Urban**	Add an introductory section about formal grievances for definition.	Agree with DHFS revision.	p. 105	See Article VIII, first paragraph, page 105.
25	**Article I Definitions**	**Dr. Urban**	Add definition of informal vs. formal grievances to general definition of grievance.	Need consistent use of terminology and process.	p. 7	See Article I, Definitions, Grievance, page 7.
26	**Article III Functions and Duties of the MCO B. General Provision of Contract Services**	**Dr. Urban**	Update language regarding transplants.	Agree with DHFS revision.	p. 15	This language will be addressed during the next contract period for all HMO contracts.
27	**Article III Functions and Duties of the MCO B. General Provision of Contract Services**	**Dr. Urban**	Eliminate Health Check contract language.		p. 18	Federal law requires Health Check services for recipients under 21.
28	**Article III Functions and Duties of the MCO S. Quality Assessment/Performance Improvement (QAPI)**	**Dr. Urban**	Delete "a psychiatrist" from 2. QAPI Program d. #4	Recommend language as "a psychiatrist or other mental health provider".	p. 41	Left language as is to retain consistency between Milwaukee and Dane programs.

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29	**Article III Functions and Duties of the MCO S. Quality Assessment/Performance Improvement (QAPI)**	**Dr. Urban**	Under #13 "Performance Improvement Priority Areas and Projects" B. "Ten steps for completing a performance improvement project Second paragraph: Change "3" to "2" in the sentence: "…not less that three (3) different projects must be reported to the Department between 2005 and 2007."	BCAP should not be mandated.	p. 61	Article III. S. 10. b., page 61. **Added language specifying that BCAP methodology is optional.**
30	**Article VI Computer Data Reporting System Data Records and Reports B. Periodic Reports**	**Dr. Urban**	Under #2, 3rd sentence, add "and Dane County" to: "The Department will work with the MCO to develop a mechanism for sharing MCO (and Dane County) specific data and blinded data from other MCOs in order for the MCO to perform their own independent analysis of the data."	Agree with DHFS comment.	p. 90	Instead of referencing this in the contract, an MOU between CLA and Dane Co. should be used.
31	**Article VIII Grievance Procedures A. Procedures**	**Dr. Urban**	Under #8, 1st sentence, replace "negative response" with "denial or reduction".	Agree with DHFS comment.	p. 103	The term "negative response" is standard language that is used in all of the HMO contracts.

Proposed Changes for the Dane County SSI MC Medicaid Contract 2005-2007

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32	**Addendum II Mental Health/Substance Abuse Requirements/Coordination of Services with Community Agencies**	**Urban**	First paragraph, 2nd sentence, insert the word "traditional" before "Medicaid-covered services". Insert the word "and" in-between: "1. a. Be certified according to HFS 105.21, 105, 22, 105.23, 105.24 and 105.255, to provide mental health and/or substance abuse services. (and) b. Have contracted with facilities and/or provider according to HFS 105.21, 105.22, 105.23, 105.24, 105.25, and/or 105.255, to provide mental health and/or mental health and/or substance abuse services; or…"	Agree with DHFS revision.	p. 139	See Addendum II, first paragragh, page 139. Putting the word "and" in would conflict with the following paragraph which states: "Regardless of whether (a) or (b) above is chosen, such treatment facilities and/or providers must provide transitional treatment arrangements in additional to other outpatient mental health and/or substance abuse services."
33	**Addendum IV Health Check**	**Urban**	Correct grammatical errors in first paragraph, #1 and #3.		p. 155	See Addendum IV, Health Check , #1 and #3, page 155.
34	**Addendum XII Performance Improvement Project Report Review Questions**	**Urban**	Eliminate this Addendum as these requirements have been included in the body of the contract.	Agree with DHFS comment.	p. 167	Eliminated this Addendum as these requirements have been included in the body of the contract.
35	**Article III Prescription Drugs**	**Dane SSI MC Advisory Committee**	Add language to the effect that pharmacy coverage is excluded for enrollees dually eligible for Medicaid and Medicare.	DHFS addressing this. Need clarity of covered pharmacy services for duals Vs non-duals soon.	p. 78	Added language to the effect that pharmacy coverage is excluded for enrollees dually eligible for Medicaid and Medicare.

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